STATE OF ARIZONA

ARIZONA DEPARTMENT OF INSURANCE

In the Matter of:	Docket No. 08A-111-INS
HUMANA INSURANCE COMPANY NAIC #73288	**CONSENT ORDER**
Respondent.	

On August 8, 2007 the Arizona Department of Insurance ('Department') called a healthcare insurance compliance examination ('Examination') of Humana Insurance Company ('HIC' or the 'Company') covering the time period from January 1, 2006 through December 6, 2007 ('Examination Period'). The Examination Period was divided into four six-month periods ('Partial Examination Periods' or 'PEPs') as follows:

PEP 1:	January 1, 2006 – June 30, 2006
PEP 2:	July 1, 2006 – December 31, 2006
PEP 3:	January 1, 2007 – June 30, 2007
PEP 4:	July 1, 2007 – December 6, 2007

The Report of the Health Insurance Compliance Examination of Humana Insurance Company dated March 3, 2008 ('Report'), which is included herein by reference, alleges that Humana Insurance Company violated Arizona Revised Statutes (A.R.S.) §§ 20-2533 through 20-2537. Humana Insurance Company wishes to resolve this matter without formal proceedings. HIC admits the following Findings of Fact are true and consents to the entry of the following Conclusions of Law solely for the purpose of resolving the allegations contained in the Report and consents to the entry of the following Order.

FINDINGS OF FACT

I. Jurisdiction.

Humana Insurance Company is, and throughout the Examination Period was, authorized to operate as a disability insurer pursuant to a Certificate of Authority issued by the Arizona Insurance Director ('Director').

II. Utilization Review and Health Care Appeals.

A. During the Examination Period, in 29 of 71 (41% of) appeals, Humana Insurance Company failed to provide a health care appeals information packet to the member within five business days after the date the appeal was initiated.

B. During the Examination Period, in 29 of 71 (41% of) appeals, Humana Insurance Company failed to notify the member of the right to appeal or failed to issue an explanation of benefits document that provided the member the correct timeframe to file an appeal.

C. During the Examination Period, Humana Insurance Company's initial determination letter appeared to provide the company discretion in deciding if an appeal that was certified by a provider would be heard as an expedited appeal.

D. During PEPs 2 and 4, in 2 of 2 (100% of) requests for expedited medical review, Humana Insurance Company failed to inform the member and the member's treating provider of the expedited decision within one business day.

E. During PEPs 2, 3 and 4, in 5 of 5 (100% of) requests for an expedited medical review where there was an adverse decision, Humana Insurance Company failed to notify the member or the member's treating provider by telephone and mail of the adverse decision or of the member's option to immediately proceed to an expedited appeal.

F. During PEPs 2, 3 and 4, in 8 of 14 (57% of) requests for informal reconsideration, Humana Insurance Company failed to mail a written acknowledgment to the member within five business days after receipt of the request, or failed to mail a written acknowledgment to the member's treating provider within five business days after receipt of the request or failed to do either.

G. During PEP 3, in 1 of 5 (20% of) informal reconsiderations, Humana Insurance Company failed, when a service or claim was denied at the conclusion of the informal reconsideration, to provide the member and the treating provider with a written statement of the agent's decision and the criteria used and clinical reasons for that decision and the option to proceed after the formal appeal process to an external independent review.

H. During the Examination Period, in 19 of 46 (41% of) formal appeals, Humana Insurance Company failed to mail a written acknowledgment to the member and the member's treating provider within five business days after receipt of the formal appeal.

I. During PEP 2, in 1 of 2 (50% of) formal appeals, where the issue was of medical necessity under the coverage document and not whether the service is covered, Humana Insurance Company failed to have a utilization review agent who is qualified in a similar scope of practice render a

decision based on the utilization review plan adopted by the utilization review agent.

J. During the Examination Period, in 9 of 22 (41% of) formal appeals, when at the conclusion of the formal appeal process the utilization review agent denies the appeal, Humana Insurance Company failed to notify the member with notice of the option to proceed to an external independent review.

K. During PEP 2, in 1 of 1 (100% of) external independent reviews, Humana Insurance Company failed to forward to the director the request for review, the terms of agreement in the member's policy, evidence of coverage or a similar document and all medical records and supporting documents.

L. During PEP 3, in 1 of 1 (100% of), when handling requests for expedited external independent reviews, Humana Insurance Company failed to mail a written acknowledgment to the director, the member, the member's treating provider and the health care insurer within one business day.

CONCLUSIONS OF LAW

I. Jurisdiction.

The Director has the authority to enter and enforce this Order. A.R.S. § 20-142.

II. Utilization Review and Health Care Appeals.

A. During the Examination Period, Humana Insurance Company violated A.R.S. § 20-2533(C) by failing to provide a health care appeals information packet to the member within five business days after the date the appeal was initiated.

B. During the Examination Period, Humana Insurance Company violated A.R.S. § 20-2533(D) by failing to notify the member of the right to appeal or failing to issue an explanation of benefits document that provided the member the correct timeframe to file an appeal.

C. During the Examination Period, Humana Insurance Company violated A.R.S. § 20-2534(A) by an initial determination letter that appeared to provide the company discretion in deciding if an appeal that was certified by a provider would be heard as an expedited appeal.

D. During PEPs 2 and 4, Humana Insurance Company violated A.R.S. § 20-2534(B) by failing, in requests for expedited medical review, to inform the member and the member's treating provider of the expedited decision within one business day.

E. During PEPs 2, 3 and 4, Humana Insurance Company violated A.R.S. § 20-2534(C) by failing, in requests for an expedited medical review where there was an adverse decision, to notify the member or the member's treating provider by telephone and mail of the adverse decision or of the member's option to immediately proceed to an expedited appeal.

F. During PEPs 2, 3 and 4, Humana Insurance Company violated A.R.S. § 20-2535(B) by failing, in requests for informal reconsideration, to mail a written acknowledgment to the member within five business days after receipt of the request, or failing to mail a written acknowledgment to the member's treating provider within five business days after receipt of the request or failing to do either.

G. During PEP 3, Humana Insurance Company violated A.R.S. § 20-2535(F) by failing, in informal reconsiderations when a service or claim was denied at the conclusion of the informal reconsideration, to provide the member and the treating provider with a written statement of the agent's decision and the criteria used and clinical reasons for that decision and the option to proceed after the formal appeal process to an external independent review.

H. During the Examination Period, Humana Insurance Company violated A.R.S. § 20-2536(B) by failing, in formal appeals, to mail a written acknowledgment to the member and the member's treating provider within five business days after receipt of the formal appeal.

I. During PEP 2, Humana Insurance Company violated A.R.S. § 20-2536(D) by failing, in formal appeals where the issue was of medical necessity under the coverage document and not whether the service is covered, to have a utilization review agent who is qualified in a similar scope of

practice render a decision based on the utilization review plan adopted by the utilization review agent.

J. During the Examination Period, Humana Insurance Company violated A.R.S. § 20-2536(G) by failing, in formal appeals when at the conclusion of the formal appeal process the utilization review agent denies the appeal, to notify the member with notice of the option to proceed to an external independent review.

K. During PEP 2, Humana Insurance Company violated A.R.S. § 20-2537(C)(2) by failing, in external independent reviews, to forward to the director the request for review, the terms of agreement in the member's policy, evidence of coverage or a similar document and all medical records and supporting documents.

L. During PEP 3, Humana Insurance Company violated A.R.S. § 20-2537(K)(2)(a) by failing, when handling requests for expedited external independent reviews, to mail a written acknowledgment to the director, the member, the member's treating provider and the health care insurer within one business day.

ORDER

IT IS HEREBY ORDERED THAT:

1. Utilization Review and Health Care Appeals. Within 90 days of the filed date of this Order, Humana Insurance Company shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP) regarding its utilization review and health care appeals violations set forth in this Consent Order. The CAP shall provide specific steps Humana Insurance Company has taken or will take by certain dates to assure that by a specified implementation date, Humana Insurance Company is:
    a. Providing a health care appeals information packet to the member within five business days after the date the appeal was initiated.
    b. Notifying the member of the right to appeal or issuing an explanation of benefits document that provides the member the correct timeframe to file an appeal.
    c. Sending an initial determination letter that does not appear to provide the company discretion to decide if an appeal that was certified by a provider would be heard as an expedited appeal.
    d. In requests for expedited medical review, notifying the member and the member's treating provider of the expedited decision within one business day.
    e. In requests for expedited medical review where there was an adverse decision, notifying the member or the member's treating provider by telephone and mail of the adverse decision and of the member's option to immediately proceed to an expedited appeal.

f. In requests for informal reconsideration, mailing a written acknowledgment to the member within five business days after receipt of the request, or mailing a written acknowledgment to the member's treating provider within five business days after receipt of the request or not failing to do either.

g. In informal reconsiderations, when a service or claim was denied at the conclusion of the informal reconsideration, providing the member and the treating provider with a written statement of the agent's decision and the criteria used and clinical reasons for that decision and the option to proceed after the formal appeal process to an external independent review.

h. In formal appeals, mailing a written acknowledgment to the member and the member's treating provider within five business days after receipt of the formal appeal.

i. In formal appeals, where the issue was of medical necessity under the coverage document and not whether the service is covered, having a utilization review agent who is qualified in a similar scope of practice render a decision based on the utilization review plan adopted by the utilization review agent.

j. In formal appeals, when at the conclusion of the formal appeal process the utilization review agent denies the appeal, notifying the member with notice of the option to proceed to an external independent review.

k. In external independent reviews, forwarding to the director the request for review the terms of agreement in the member's policy, evidence of coverage or a similar document and all medical records and supporting documents.

l. When handling requests for expedited external independent reviews, mailing a written acknowledgment to the director, the member, the member's treating provider and the health care insurer within one business day.

2. Progress in Development of the CAP. Until the Director approves the CAP, Humana Insurance Company shall report to the Director each month on its progress in the development of the CAP. Each such monthly report shall include a current draft of the CAP. The first monthly CAP development report is due to the Director 30 days from the date of this Order.

3. Corrective Action Plan Requirements. The CAP described above shall:

   a. Specify any CAP items ('a' through 'l') that the Director has in writing either approved as ready for implementation or accepted as implemented before the date of the report and for each one include:

      i. documentation of the implementation or progress toward implementation, as applicable,

      ii. post implementation Quality Improvement review and follow-up, and

      iii. the name and contact information for one individual responsible for ongoing implementation of the item.

   b. Specify the CAP items ('a' through 'l') that the Director has not approved as ready for implementation or accepted as implemented as of the date of the report and for each one include:

      i. enough detail to allow the Director to determine whether the CAP will accomplish its purpose,

      ii. testing before final implementation of the CAP,

iii. post implementation Quality Improvement review and follow-up, and

iv. the name and contact information for one individual responsible and accountable for ongoing implementation of the item.

c. Provide for Humana Insurance Company to report to the Director each month regarding implementation of each approved item of the CAP, in a form that includes documentation and is approved by the Director. If any item of the CAP has been implemented, provide documentation that demonstrates the results of the changes. If any item of the CAP is in the process of implementation, provide documentation that demonstrates the progress that has been made

d. Provide that within 10 business days of receipt of notice that the Director has approved any item of the CAP, Humana Insurance Company shall submit to the Director evidence that Humana Insurance Company has communicated any item of the CAP to the appropriate personnel and begun implementation. Evidence of communication and implementation includes, without limitation, memos, bulletins, e-mails, correspondence, procedure manuals, print screens and training materials.

4. Civil Penalty. Humana Insurance Company shall pay a civil penalty of $23,625.00 to the Director for deposit in the State General Fund for violations cited above as Conclusions of Law. Humana Insurance Company shall remit this civil penalty to the Life & Health Division of the Department prior to the Department filing of this Order.

The Department will file the Report of the Health Insurance Compliance Examination of Humana Insurance Company upon the filing of this order.

DATED at Phoenix, Arizona this 20th day of June, 2008.

Christina Urias
Director of Insurance

CONSENT TO ORDER

1. Humana Insurance Company has reviewed the foregoing Order and carefully considered it in conjunction with its other business and regulatory requirements. Humana Insurance Company believes that it is able and prepared to comply fully with the order, notwithstanding any of its other business and regulatory requirements.

2. Humana Insurance Company admits the jurisdiction of the Director of Insurance, State of Arizona, admits the Findings of Fact and consents to the entry of the Conclusions of Law solely for the purposes of resolving the allegations contained in the Report and consents to entry of the Order.

3. Humana Insurance Company is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. Humana Insurance Company irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.

4. Humana Insurance Company states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.

5. Humana Insurance Company acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter. This Order does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future and does not

preclude the Department from instituting proceedings as may be appropriate on other matters now or in the future.

6. Michael B. McCallister, who holds the office of President and Chief Executive Officer, is authorized to enter into this Order for Humana Insurance Company and on its behalf.

Humana Insurance Company

June 11, 2008
Date

By _____
Michael B. McCallister
President and Chief Executive Officer
Humana Insurance Company

COPY of the foregoing mailed/delivered this 24th day of Jun, 2008, to:

Gerrie Marks
Deputy Director
Mary Butterfield
Assistant Director
Consumer Affairs Division
Paul J. Hogan
Market Oversight Division Chief
Dean Ehler
Assistant Director
Rates & Regulations Division
Steve Ferguson
Assistant Director
Financial Affairs Division
David Lee
Chief Financial Examiner
Alexandra Shafer
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